



IN THE CORONERS COURT
OF VICTORIA
AT MELBOURNE

COR 2024 004807

FINDING INTO DEATH WITHOUT INQUEST

Form 38 Rule 63(2)

Section 67 of the Coroners Act 2008

Findings of: Judge John Cain, State Coroner

Deceased: Kerry Swift

Date of birth: 10 May 1959

Date of death: 23 April 2023

Cause of death: 1(a) Community acquired pneumonia

Contributing factor(s)
2 Urinary tract infection

Place of death: Monash Health, 246 Clayton Road, Clayton,
Victoria 3168

Keywords: Specialist Disability Accommodation resident,
supported independent living, disability support,
reportable deaths, natural causes

INTRODUCTION

1. On 23 April 2023, Kerryn Swift was 63 years old when she passed away at Monash Medical Centre.
2. At the time of her death, Ms Swift was a National Disability Insurance Scheme (NDIS) participant. She received funding to reside in a Specialist Disability Accommodation (SDA) enrolled dwelling¹ provided by the then-Department of Health and Human Services. Ms Swift was receiving these supports due to multiple sclerosis (MS) with associated functional impairment. Ms Swift required a wheelchair and hoist for her mobility needs.
3. Ms Swift enjoyed attending a weekly art class run by Phoenix Park on Wednesdays, however many of her social and community outings were curtailed due to COVID-19 restrictions.

THE CORONIAL INVESTIGATION

4. Ms Swift's death was reported to the coroner as it fell within the definition of a reportable death in the *Coroners Act 2008* (the Act) as she was a 'person placed in custody or care' within the meaning of the Act, as a person receiving funding for Supported Independent Living (SIL) and residing in an SDA enrolled dwelling immediately prior to her death. This category of death is reportable to ensure independent scrutiny of the circumstances leading to death given the vulnerability of this cohort and the level of power and control exercised by those who care for them. The coroner is required to investigate the death, and publish their findings, even if the death has occurred as a result of natural causes.
5. The role of a coroner is to independently investigate reportable deaths to establish, if possible, identity, medical cause of death, and surrounding circumstances. Surrounding circumstances are limited to events which are sufficiently proximate and causally related to the death. The purpose of a coronial investigation is to establish the facts, not to cast blame or determine criminal or civil liability.

¹ SDA enrolled dwelling is defined under the *Residential Tenancies Act 1997* (Vic). The definition, as applicable at the time of Ms Swift's death, is a permanent dwelling that provides long-term accommodation for one or more SDA residents, that is enrolled as an SDA dwelling under relevant NDIS (Specialist Disability Accommodation) Rules in force at the relevant time. An SDA resident means a person who is an NDIS participant funded to reside in an SDA enrolled dwelling, or who receives continuity of supports under the Commonwealth Continuity of Support Program in respect of specialist disability services for older people (from 1 July 2021, the Disability Support for Older Australians program). The definition of SDA resident was amended on 1 July 2024 pursuant to the *Disability and Social Services Regulation Amendment Act 2023* to extend to include persons who are residing, or propose to reside, in an SDA dwelling under an SDA residency agreement or residential rental agreement.

6. Under the Act, coroners also have the important functions of helping to prevent deaths and promoting public health and safety and the administration of justice through the making of comments or recommendations in appropriate cases about any matter connected to the death under investigation.
7. This finding draws on the totality of the coronial investigation into the death of Kerryn Swift including information from the National Disability Insurance Agency (**NDIA**) and the NDIS Quality and Safeguards Commission, as well as a Medical Certificate Cause of Death (**MCCD**) completed by a medical practitioner at Monash Medical Centre. Whilst I have reviewed all the material, I will only refer to that which is directly relevant to my findings or necessary for narrative clarity. In the coronial jurisdiction, facts must be established on the balance of probabilities.²

MATTERS IN RELATION TO WHICH A FINDING MUST, IF POSSIBLE, BE MADE

Circumstances in which the death occurred

8. On 20 April 2023, Ms Swift was feeling unwell and her general practitioner (**GP**), Dr Debbie Yiap, prescribed her with antibiotics for a likely chest infection. Ms Swift's carers observed that she was still unwell and contacted the locum GP service. Ms Swift's condition continued to decline so they requested an ambulance.
9. Ms Swift was transferred to Monash Medical Centre, where her condition deteriorated further, and she passed away on 23 April 2023.

Identity of the deceased

10. On 23 April 2023, Kerryn Swift, born 10 May 1959, was identified by medical practitioner Dr Yu Wen Kevin Wu via review of medical records and visual identification.
11. Identity is not in dispute and requires no further investigation.

Medical cause of death

12. On 23 April 2023, medical practitioner Dr Yu Wen Kevin Wu reviewed Ms Swift's complete medical history, conducted an examination of the body and completed a MCCD. Dr Wu

² Subject to the principles enunciated in *Briginshaw v Briginshaw* (1938) 60 CLR 336. The effect of this and similar authorities is that coroners should not make adverse findings against, or comments about, individuals unless the evidence provides a comfortable level of satisfaction as to those matters taking into account the consequences of such findings or comments.

provided an opinion that the medical cause of death was community acquired pneumonia, with a urinary tract infection as a significant contributing condition.

13. On 17 August 2024, a Medical Liaison Nurse (MLN) at the Victorian Institute of Forensic Medicine, reviewed the MCCD at my direction and confirmed that the cause of death was due to natural causes.
14. I accept Dr Wu's opinion and am satisfied that the death was due to natural causes.

FINDINGS AND CONCLUSION

15. Pursuant to section 67(1) of the *Coroners Act 2008* I make the following findings:
 - a) the identity of the deceased was Kerry Swift, born 10 May 1959;
 - b) the death occurred on 23 April 2023 at Monash Health, 246 Clayton Road, Clayton Victoria 3168, from community acquired pneumonia with urinary tract infection as a significant contributing factor; and
 - c) the death occurred in the circumstances described above.
16. The available evidence does not support a finding that there was any want of clinical management or care on the part of the SIL provider, or clinical staff at Monash Medical Centre, that caused or contributed to Ms Swift's death.
17. Having considered all the available evidence, I find that Ms Swift's death was from natural causes and that no further investigation is required. As such, I have exercised my discretion under section 52(3A) of the Act not to hold an inquest into her death and to finalise the investigation of Ms Swift's death in chambers.

I convey my sincere condolences to Ms Swift's family, friends and carers for their loss, and acknowledge the distress caused by the delay in the reporting and investigation of Ms Swift's death.

Pursuant to section 73(1B) of the Act, I order that this finding be published on the Coroners Court of Victoria website in accordance with the rules.

I direct that a copy of this finding be provided to the following:

David Cox

MS Plus Ltd

Monash Health

Signature:



Date: 13 December 2024

NOTE: Under section 83 of the *Coroners Act 2008* ('the Act'), a person with sufficient interest in an investigation may appeal to the Trial Division of the Supreme Court against the findings of a coroner in respect of a death after an investigation. An appeal must be made within 6 months after the day on which the determination is made, unless the Supreme Court grants leave to appeal out of time under section 86 of the Act.
